

March 25, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0680-01
IRO #: 5251

____ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ____ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ____ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

____ is a gentleman who on ____, sustained an injury to his low back and left knee. He failed conservative treatment with his knee and underwent arthroscopic surgery of partial lateral meniscectomy and excision on patellofemoral plica and has improved with that aspect of his injury, to the point of maximum medical improvement in October of 2002. He continues to have low back pain. An MRI revealed L4/5 and L4/S1 disc bulging. An EMG by ____ showed a moderately severe L5 radiculopathy. A request was made for an Orthotrac pneumatic vest, but the request was denied by the carrier. Meanwhile, the patient underwent a discogram which was negative and a CT myelogram which did not identify any further pathology. The patient has been on Norco, Zofran, Percocet and Lexapro with continued pain in his back and left hip and leg.

REQUESTED SERVICE

The purchase of an Orthotrac Pneumatic Vest is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no reference in the clinical information that the patient's pain is aggravated by standing and relieved by lying down. The only notation referring to worsening pain with standing is in the application for the orthotic device and not in the clinical notes associated with his office visits. There is also no indication that this patient has ever had traction, and that the traction was helpful in relieving his pain.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 25th day of March 2003.